High Value Healthcare for Diverse Populations

Sunday, December 6, 2015
1:00 – 4:30pm

Session Objectives

- Present evidence on disparities in health care
- Identify links between value, quality and equity
- Describe the approaches taken by health care organizations to deliver quality care to diverse populations

Outline

- High-Value, Transformation and Equity
- Key Drivers
- Lessons from the Field

Agenda

Welcome and summary on the field of disparities and the Disparities Leadership Program
Disparities Solutions Center
Joseph R. Betancourt, M.D., M.P.H.
Aswita Tan-McGrory, MBA, MSPH

Break (20 min)

Health Connections: An Interdisciplinary Approach to Improved Care Coordination for Vulnerable Patients
KentuckyOne Health Care
Bev Beckman, RN, CPHQ, ACM

BCBSMA Disparities Action Team and the Disparities Leadership Program
Blue Cross Blue Shield of Massachusetts
Thomas C. Hawkins, M.D., M.S.

AnMed Health and the Disparities Leadership Program:
An Illustration of Cultural and Linguistic Competence
AnMed Health
Juana Slade, CDM, CCF

Improving Quality and Achieving Equity
Delivering Value in a Time of Healthcare Transformation
Joseph R. Betancourt, M.D., M.P.H.
Director, The Disparities Solutions Center
Senior Scientist, Morgan Institute for Health Policy
Director for Multicultural Education, Massachusetts General Hospital
Associate Professor of Medicine, Harvard Medical School

High-Value in A Time of Healthcare Transformation

Value-based purchasing and health care reform will alter the way health care is delivered and financed; quality not quantity…

- Increasing Access: Assuring appropriate utilization
  - Linking to the PCMH, decreasing ED use & avoidable hospitalizations
- Improving Quality: Providing the best care
  - Importance of Wellness, Population Management
- Controlling Cost: Focusing on the Pressure Points
  - Importance of hot spotting and preventing readmissions, avoiding medical errors, and improving patient experience
  - Banding together and risk-sharing through ACO’s
Increasing Diversity

Health care organizations need to prepare staff to work with patients and colleagues from diverse cultural backgrounds.

Current and Projected Resident Population of the United States, 1998-2030

<table>
<thead>
<tr>
<th>Year</th>
<th>White</th>
<th>Black</th>
<th>Hispanic/Latino</th>
<th>Asian/Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>50.1</td>
<td>33.6</td>
<td>18.4</td>
<td>18.4</td>
</tr>
<tr>
<td>2030</td>
<td>50.3</td>
<td>18.4</td>
<td>18.4</td>
<td>18.4</td>
</tr>
</tbody>
</table>


Diabetes-Related Death Rate, 2012

Deaths per 100,000 population

- White: 22.8
- Black: 33.6
- Hispanic/Latino: 50.3
- Asian/Pacific Islander: 18.4

What causes these Racial/Ethnic Disparities in Health?

- **Social Determinants**
- **Access to Care**
- **Health Care?**

Racial and Ethnic Disparities in Health Care

A High-Value Target

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for. Many sources contribute to disparities—no one suspect, no one solution.

- Navigation
- Communication
- Stereotyping
- Mistrust

Variations in care and quality, inefficiencies, costly care and poor outcomes are the epitome of low-value.

Linking Disparities to Quality and Safety and the Pressure Points

- **Safe**
  - Minorities have more medical errors with greater clinical consequences
- **Effective**
  - Minorities received less evidence-based care (diabetes)
- **Patient-centered**
  - Minorities less likely to provide truly informed consent; some poorer patient experience
- **Timely**
  - Minorities more likely to wait for same procedure (transplant)
- **Efficient**
  - Minorities experience more test ordering in ED due to poor communication
- **Equitable**
  - No variation in outcomes
- **Also**
  - Minorities have more CHF readmissions, and avoidable hospitalizations

IOM's Unequal Treatment

www.nap.edu

Recommendations

- Increase awareness of existence of disparities
- Address systems of care
  - Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  - Improve workforce diversity
  - Facilitate interpretation services
- Provider education
  - Health Disparities, Cultural Competence, Clinical Decisionmaking
- Patient education (navigation, activation)
- Research
  - Promising strategies, Barriers to eliminating disparities
Disparities Leadership Program Objectives

At the conclusion, participants will be able to:

- Articulate the ways in which equity is linked to healthcare transformation, health care reform, value-based purchasing, accreditation and quality measurement.
- Identify strategies to secure buy-in by having health care leaders better understand these links and become invested in addressing them.
- List techniques and technology for race and ethnicity data collection and disparities/equity performance measurement.
- Identify interventions to reduce disparities in health care with a particular focus on preventing readmissions and avoidable hospitalizations, improving patient safety and experience, and deploying culturally competent population management initiatives.
- Identify ways to message the issue of equity both internally and externally.
- Describe a concrete step that their organization will take towards improving quality, addressing disparities and achieving equity.

Disparities Leadership Program Alumni

- Disparities Leadership Program has trained:
  - 311 participants
  - 142 organizations
    - 77 hospitals
    - 31 health plans
    - 21 community health centers
    - 8 professional organizations
    - 1 pharmaceutical company
    - 1 school of medicine
    - 1 hospital trade organization
    - 1 federal government agency
    - 1 city government agency

Our Vision: The Disparities Leadership Program

- To arm health care leaders with rich understanding of the causes of disparities and the vision to implement solutions and transform their organization to one delivering high-value care.
- To help leaders create strategic plans and projects to advance their work in reducing disparities in a customized way, with practical benefits tailored to every organization.
- To align the goals of health equity with health care reform and other strategic imperatives designed to improve value.

Curriculum

- Two day kick off meeting in Boston in May
- Three web-based collaborative group calls
- Three team technical assistance calls
- Two web seminars on topics relevant to the DLP
- Two day meeting in CA in February

DLP Organizations

31 states
Commonwealth of Puerto Rico
Canada, Switzerland

Disparities Leadership Program Alumni

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Post DLP Collaborations

- Transforming Healthcare: Intersection with Health Equity (Minneapolis)
- Pediatric Health Equity Collaborative (Nashville, Kansas City)
- DLP Alumni meeting (Santa Monica)
- The Healthcare Quality and Equity Action Forum (Boston)
- DLP Mid-Atlantic Alumni Collaborative

MN DLP Alumni Meetings

- Allina Hospitals and Clinics
- Blue Cross Blue Shield of Minnesota
- Children’s Hospitals and Clinics of MN
- Hennepin County Medical Center
- HealthEast Care System
- Mayo Clinic
- Regions Hospital

Pediatric Health Equity Collaborative

The Pediatric Health Equity Collaborative (PHEC) is comprised of 11 organizations working together with the goals of establishing best practices, lessons learned, and recommendations for the field with regard to race, ethnicity, language, and other demographic data collection in pediatric care settings.

Mid-Atlantic Alumni Collaborative

The Mid-Atlantic Collaborative, formed in October 2015, includes 50 DLP alumni from Delaware, Maryland, North Carolina, New Jersey, New York, and Pennsylvania.
Objectives

- Provide an overview of one intervention developed by a participant in the Disparities Leadership Program
- Share the background for addressing health disparities in one community in Kentucky
- Discuss the importance of community engagement in program development
- Review lessons learned, challenges and solutions
- Share current outcomes and improvements in health, quality and cost/value as a result of the program
- Share tools for those interested in the development of a similar program

For More Information Contact:
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Break (20 min)
2:40-3:00 pm

Health Connections
An Interdisciplinary Approach to Improved Care Coordination for Vulnerable Patients

Bev Beckman, RN, CPHQ, ACM

Healthcare Quality and Equity Action Forum

September 29-30th, 2016
Boston Seaport Hotel

• Provides the background, key drivers and essential strategies to improve quality and achieve equity as a time of rapid healthcare system change.
• Sets the stage for an interdisciplinary dialogue between all key healthcare stakeholders, including payers and providers of services.
• Provides the stage for an interdisciplinary dialogue between all key healthcare stakeholders, including payers and providers of services.
• Participants have included leaders from multiple disciplines and healthcare organizations— including those from health plans, healthcare systems, and children’s hospitals, to name a few— who work in the areas of:
  • quality and safety
  • disparities, diversity, and equity
  • health policy
  • healthcare design and delivery

Our Future
To transform the health care communities, care delivery and health care professions so that individuals and families can enjoy the best of health and wellbeing.
Background

• Persistent disparities in health care underscore the urgent need for more effective interventions.
• *Unnatural Causes* documentary illustrated the impact of social determinants of health in a east-to-west drive across Louisville.

Upstream to Equity to Health Connections Initiative

• In 2010, Jewish Hospital forged a community partnership with the residents of the challenged neighborhoods and the Louisville Metro Department of Health and it’s Center for Health Equity to identify needs, establish priorities, and develop an action plan to promote improved health status, effective health care with a goal to move “upstream” to achieve health equity for all.
• In 2011 and 2012, one stakeholder from each agency participated as a team in the one year Disparities Leadership Program
• The goal was to develop a project that would support a collaborative improved community care transitions program, study the problem and develop an intervention that would result in improved patient outcomes and health equity.
• This project established as a result of participation in the DLP has evolved between 2011 and 2015 to an effective Interdisciplinary Outreach Care Team model that has been scaled to other facilities across the country.

The Evolution of a Model

Grounded in addressing health disparities

A Lessons Learned Model

• Executive Leadership – VP of Healthy Communities
• Stakeholder Coordinating Committee (internal team)
  – Informatics: Identify systems and metrics
  – Finance: Develop budget
  – Nursing: Touches on all patients
  – Case Management: Transitions of care and patient identification
  – Language & Cultural Services: Multi-cultural needs
  – Home Care: Program operator with key competencies and understanding of community programs, barriers and resources

Community as Partners – Steering Committee

Community partnerships are essential in program development and ongoing communication related to access and elimination of barriers to community resource needs.

  – Federally Qualified Health Centers
  – Patient Centered Medical Homes / PCP Group Practices
  – Behavioral Health
  – Payers / Managed Care Medicaid
  – Emergency Medical Services
  – Faith Ministries / Mission Leader
  – Community focus groups

Interoperable Systems

Interoperable computer systems are critical. Perform an inventory to identify systems and determine if they will meet the needs:

  – Patient referral identification
  – Risk stratification
  – Documentation of services provided
  – Team member communication
  – Dashboards –monthly report on Triple Aim metrics
Designing A Program – The Team of Experts

A team of subject matter experts is needed short-term to develop the program, outline the process and identify work tools.

- Benchmark best practice models (Camden, Eric Coleman)
- Use evidence based tools
  - PHQ9, - Depression
  - Stanford – Self Efficacy
  - CPCQ – Coordination and Patient Experience
- Build on “lessons learned” by others
- Develop a process flow diagram; use it and revisit periodically

Key Takeaways

- Build trust and develop relationships
- Set patient-centered goals
- Coach for disease management
- Handoff to the Community Health Worker
- Identify the need for behavioral health
- Conduct social needs assessment and interventions
- Engage patients through Motivational Interviewing
- The MD is a partner
- Tell the story in the words of the patient

Outcomes: Better Health

<table>
<thead>
<tr>
<th>30-Day Readmission Rate</th>
<th>Baseline Year</th>
<th>Intervention Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed</td>
<td>24.0%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Expected</td>
<td>25.3%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Mean Observed/Participant</td>
<td>21.5%</td>
<td>22.3%</td>
</tr>
</tbody>
</table>

Outcomes: Quality

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Mean</th>
<th>Intervention Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Scale</td>
<td>4.18</td>
<td>7.21</td>
</tr>
<tr>
<td>Chronic Disease Self-Efficacy</td>
<td>5.81</td>
<td>5.81</td>
</tr>
<tr>
<td>Medical Home Connection</td>
<td>4.26</td>
<td>4.46</td>
</tr>
</tbody>
</table>
Outcomes: Cost/Value

- Eyes in the home
- A team with a heart for the work
- Love and support

BCBSMA Disparities Action Team
and the Disparities Leadership Program

Institute for Healthcare Improvement

27th Annual National Forum on Quality Improvement in Health Care, Orlando, FL

Learning Lab "High Value Healthcare for Diverse Populations"
December 6, 2015

Thomas C. Hawkins, M.D., M.S.
Senior Medical Director, Population Health and Analytics, BCBSMA
Instructor, Population Medicine – part time, Harvard Medical School

Background and Agenda

- A large national company asked about their disparities
- We began with analytics, and participated in the MGH Disparities Leadership Program
- Reviewed intervention literature, including use of Community Health Workers
- Presented initial findings and first community mapping from BCBS Association’s CHM Hub
- Launched a long term project, realized more organizational structure needed for the long haul
- Engaged our Employee Resource Groups for advice

Health Disparities Action Team Structure

- Vision: Enable BCBSMA to achieve market leadership in identifying and addressing population health disparities through active engagement with our members, accounts, and providers.

Disparities Analytics
- Scope & Activities:
  - Conduct population-based analytics to identify disparities in equities across member populations and sub-populations
  - Conduct analysis to measure, monitor, and evaluate the effectiveness of account, provider, and direct-to-member approaches to reduce disparities

Interventions
- Scope & Activities:
  - Develop BCBSMA portfolio of best practices to support interventions in the account, provider, and direct-to-member channels

Marketing & Communications
- Scope & Activities:
  - Package and brand health equity capabilities for accounts, providers, and members
  - Develop a portfolio of culturally and linguistically appropriate approaches for direct-to-member engagement

Intervention Stakeholders
- Intervention Channels
Segmenting A Population: 
Breaking down and rolling up looking for variation and opportunity 'hot spots'

Well-Visit Rate by Work Environment

<table>
<thead>
<tr>
<th>Work Environment</th>
<th>Percent of Adults Who Received a Well Visit Once in the Past 3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>77.8</td>
</tr>
<tr>
<td>District</td>
<td>79.8</td>
</tr>
<tr>
<td>Retail</td>
<td>51*</td>
</tr>
<tr>
<td>Distribution</td>
<td>69.3*</td>
</tr>
</tbody>
</table>

* Denotes disparities compared to corporate population

Hypertension and Diabetes Disparities Based on Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Diabetes Rate (per 1000)</th>
<th>Hypertension Rate (per 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>60.6</td>
<td>216.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>95.3*</td>
<td>218.6</td>
</tr>
<tr>
<td>Asian</td>
<td>95.4*</td>
<td>218.6</td>
</tr>
<tr>
<td>African-American</td>
<td>78*</td>
<td>216.8</td>
</tr>
</tbody>
</table>

* Denotes disparities compared to White population

What do the surrounding communities look like?
The BCBS Association's CHM-Hub

Update on ABC Corp Activities - Phases 1 & 2

Phase I
- Successful development and distribution of materials (in multiple languages) for ABC employees informing them of:
  - $0 copay for preventive care visits
  - Tools available to help increase Access to Care (FAD and Cost Estimator)

Phase II
- Successful implementation of onsite biometric screenings to support employee health and wellness at each Distribution Center location
  - Collaborative participation by BCBSMA and ABC Occupational Nurses
  - BCBSMA collateral available during event
  - Interpreter available at select sites
Implementation of Phase One

WELL VISIT DISPARITIES:
Developed Zero Co-Pay Postcards that were mailed to all ABC employees (Corporate and Distribution Centers)
Translated Postcards into 5 languages for manual distribution (Spanish, Russian, Albanian, Cantonese, and Vietnamese)

ACCESS TO CARE:
Developed Cost Estimator- Find a Doctor Postcards that were mailed to all ABC employees (Corporate and Distribution Centers)

Implementation of Phase Two

On-site Biometric Screening to support employee health including: Diabetes, Hypertension, Cancer Screening and Access to Care

Early Successes/Challenges
- Immediate feedback from occupational nurses
- One site had interpreters available
- ABC commitment has been strong
- Limited time of associates to be off the line
- Complexity of benefits
- Inconsistent approaches from the distribution center leadership

Preliminary Results

Increase in the Well Visit rate

Well Visits

<table>
<thead>
<tr>
<th>Location</th>
<th>Sessions per day</th>
<th>Total days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomfield, CT</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bridgewater, VA</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Philadelphia, PA</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Charlotte, NC</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Phase III - XYZ Distribution Center Pilot

Main Objectives
1. Develop a pilot intervention to increase the number of ABC employees enrolled with primary care services in their area
2. Increase employee knowledge of ABC resources available to assist them in seeking primary care services
3. Identify culturally competent health care resources available to employees in their area

Current Activities
- Initial intervention strategy session held with ABC representatives
  - ABC stressed importance of holiday season (Oct-Jan) during which employees have limited time to be engaged in additional activities
- Development of "intake" survey to collect additional data elements from ABC employees to support pilot intervention (i.e., email address, preferred mode of communication, preferred language, etc.)

Learning from employers and employees: The role of discovery

- Important to recognize we don’t understand most local situations, the exact solution for those communities, or ‘how’ best to accomplish change – needed to ask those who are willing to explore and ask questions
- Varying employer situations – unions, manufacturing, hospitals
- Asking manager and employee groups for insights - facilitation depends on data, credibility, trust, listening
- One disparity reappearing across numerous employers: socioeconomic, cultural, geographic disparities varying considerably from corporate headquarters

BCBSMA Employee Resource Groups (ERGs)

BCBSMA ERGs help us understand barriers and opportunities in their communities, and they are energized to help mitigate disparities
Barriers and Challenges

• Ability of employers to implement complex and new disparities-based interventions
• Interventions outside of health plan’s traditional approaches – not typical CM/DM/UM or provider/contract and involve community resources
• Time – intervention process takes time, human behavior change takes time, and community cultural changes take even longer

Three Critical Success Factors

• Organization for the long haul
• Be realistic about what can really be implemented and what will change
• Listen to the community and learn

Questions?

Our Mission

to passionately blend the art of caring with the science of medicine to optimize the health of our patients, staff and community

Our Vision

to be recognized and celebrated as the gold standard for healthcare quality and community health improvement

AnMed Health and the Disparities Leadership Program: An Illustration of Cultural and Linguistic Competence

Institute for Healthcare Improvement
27th Annual National Forum on Quality Improvement in Health Care, Orlando, Florida
Learning Lab “High Value Healthcare for Diverse Populations”
December 6, 2015

Juana Slade, CDM, CCP, Director of Diversity and Language Services
AnMed Health
Anderson, South Carolina

AnMed Health Quick Facts

✓ 690 Beds
✓ Level II Trauma Center
✓ ED Visits: 112,329
✓ Medical Staff: 466
✓ Employees: 3,800
Reframing the Conversation

Diversity
Tradional  →  Inclusive

The Secret Sauce!...DOCUMENTATION

Most of the time  →  Every patient, every time

Chief Collaborative Officer

Administration, Human Resources, Medical Staff, Financial Services, Quality/Safety Nursing/Patient Care Services, Emergency Services, Women’s Health, Children’s Health, General Counsel, Community Relations, Public Relations, Corporate Compliance, Internal and External Stakeholders, Patients, Families, Health Information Management (Medical Records,) Local, National and International Corporate Communities, Training and Organizational Development, Physician Network Services, Regional Colleges and Universities, etc.

2011 – 2013 The Perfect Cultural Competency Storm

- Enhance Culturally and Linguistically Appropriate Service Standards (CLAS)
- Joint Commission’s Roadmap Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Communication Standards
- National Call to Action
- Social Determinants of Health
- The Triple Aim

Our Project
Disparities Leadership Program
AnMed Health: Disparities Dashboard

Abstract
The goal of our project was to research and develop a disparities dashboard to identify and strategically address AnMed Health’s most vulnerable, underserved and costly patient populations. The disparities dashboard is adjunct to our system-wide quality measures and management strategies.

Project Objectives

I. Establish dashboard implementation team
II. Establish dashboard framework
III. Identify priority populations
IV. System engagement
V. Measure, monitor, enhance

Project Elements

Administrative/Executive Support
Competing organizational priorities
  • Moving disparities ‘conversations’ forward
Established dashboard framework
  • Methodology and Data Set
Physician Sponsor
  • Matt Cline, MD, Director, Family Medicine Residency Program
Resources / Implementation Team Talent
Dashboard Components

**Quality**
- Appropriate Care Scores
  - HF, AMI, CAP, SCIP
- Patient Satisfaction
  - H-CAHPS
- Readmissions

**Disparities**
- Diversity Snapshot
- Service Volumes
- Business Line Analysis
- Language Services

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**Challenges and Opportunities**

- Medical Sponsorship
- Inpatient Focus
- Intervention Team Transition
- Collaborative Opportunities
- Executive Transition

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**Progress!!**

- Disparities Dashboard
- Transitional Care Coordination
- ED Case Management and Discharge Planning
- SC Health Outcomes Program (HGP)
- Video Remote Interpreting
- Year 1 Data Language Service Compliance Plan
- Interpretation cost per encounter
- Quality/Safety
- Industry Leadership: EOC(123)/The SC Alliance

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**Appropriate Care Score Populations**

- Heart Failure (HF)
- Acute Myocardial Infarction (AMI)
- Pneumonia (CAP)
- Stroke (SCIP)

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**Patient Experiences with Care**

- Overall Rating
- % of Responses in Best Category
- Language Services Outpatient Services Inpatient Services Total

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**Language Services**

- Farsi (Persian)
- Russian
- German
- Chinese/Mandarin
- Sign Language
- Other

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**Quality Measures**

- Venous thromboembolism prophylaxis timely
- Beta blocker prior to admission and perioperative period
- Appropriate hair removal
- Cardiac surgery patients with controlled 6 a.m. postop serum glucose
- Discontinuation of prophylactic antibiotics within 24 hours after surgery
- Appropriate selection of prophylactic antibiotics
- On-time prophylactic antibiotic selection

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**PN Appropriate Care Score (ACS)**

- Initial antibiotic selection for CAP in immunocompetent - Non ICU patient
- Blood cultures w/ 24 hours of hosp arrival - pts transferred/admitted to the ICU
- Statin at discharge
- Primary PCI received within 90 minutes of hospital arrival
- Beta Blocker prescribed at Discharge
- ACEI or ARB for LVSD
- Aspirin Prescribed at discharge

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**HF Appropriate Care Score (ACS)**

- Antithrombotic therapy by end of hospital day
- Thrombolytic therapy
- Anticoagulation for atrial fibrillation
- Discharged on antithrombotic therapy
- Stroke patients with VTE prophylaxis

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**National Hospital Quality Measures 1-7**

- SCIP
- APPROPRIATE CARE SCORES (ACS)
- VTE discharge instructions
- VTE patients receiving unfractionated heparin with monitoring by protocol
- ICU VTE prophylaxis
- VTE prophylaxis
- Assessed for rehab
- Antithrombotic therapy by end of hospital day
- Thrombolytic therapy
- Anticoagulation for atrial fibrillation
- Discharged on antithrombotic therapy
- Stroke patients with VTE prophylaxis
Food for Thought
- Collaboration
- Qualitative and Quantitative Intelligence
- Expect the Unexpected
- Engage a talented, diversity team
- Consider the principle of tight-loose-tight

Questions?

For More Information About The Disparities Leadership Program

www.mghdisparitiessolutions.org

Contact: Aswita Tan-McGrory, MBA, MSPH
Deputy Director
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617-643-2916

Please turn in evaluations to Aswita Tan-McGrory.
Thank you!